

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan: _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

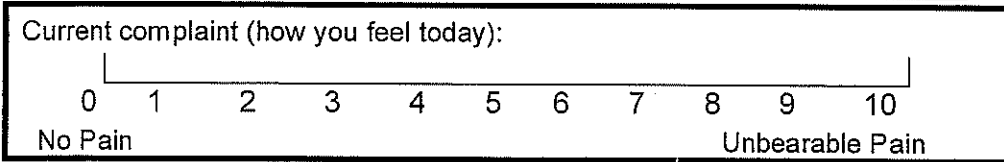
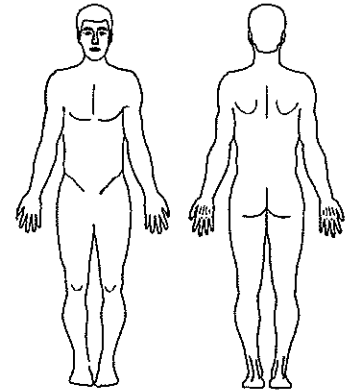
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck Pain Mid-back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

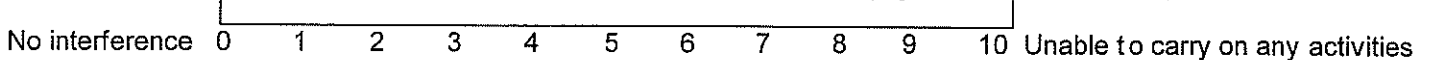
How Problem Began: _____



How often are your symptoms present?

- (Intermittent) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortis one, prednisone, etc.) | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Epilepsy/Seizures | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Medications _____ |
| _____ | _____ |
| _____ | _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ Date _____



2354 Maritime Drive, Suite 100 Elk Grove, CA 95758
Phone: (916)683-3900 • Fax: (916) 683-3339

Brett J. Lemire, D.C., CSCS
Nancy Lee Gambelli-Lemire, D.C.
Nelson S. Ong, D.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to chiropractic care including examination, chiropractic adjustments and therapeutic exercise and modalities, such as ultrasound and electric stimulation, etc, the use of diagnostic x-rays on me, or the patient whom I am legally responsible, by Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, or any other licensed doctor of chiropractic that may be employed in their absence.

I understand that chiropractic care involves the use of the hands to provide a chiropractic adjustment in such a way to restore proper motion to the joints. I understand that there are risks involved in chiropractic care just as there is in any health care. Some of the risks involved, but not limited to, are fractures, disc injury, sprains or strains, dislocation, and strokes.

These complications are generally regarded as rare. The subject of stroke and chiropractic adjustments has been subject to debate in and out of the profession, with one prominent authority saying that the chance of stroke is approximately one in a million adjustments (S.Haldeman, DC, MD) We employ tests in our exams that are designed to identify if you may be susceptible to such an injury as stroke.

I have had an opportunity to discuss the possible risks and benefits with the doctor and I am aware that results are not guaranteed.

I have read or have had read to me the above consent form and intend that this form will cover the entire course of treatment for my present condition and for any future care that I may receive from Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, or any other licensed doctor of chiropractic working in their stead.

Print Patient's Name

Print Representative's Name

Signature of Patient

Signature of Representative

Date Signed

Relationship of Representative

Witness

Date Signed

Date Signed

MEMBER BILLING ACKNOWLEDGMENT

Chiropractic

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____, a member being treated by Dr. _____,
(Name of Patient/Member/Subscriber) (Chiropractor Name)
do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
		\$
	Myo-fascial Release	\$ 15.00
		\$
		\$
		\$
		\$

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Chiropractor may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the member to agree to "self pay" for specific services in advance.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial arrangements with my chiropractor,

Dr. _____, to pay for these services myself.
(Chiropractor Name)

Dated at EIK GROVE, CA this _____ day of _____, 20____.
(city) (state) (date) (month) (year)

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date

Lemire Chiropractic Spine & Sport, Inc

(NDI/ Neck Disability Index)

Patient Name: _____ Date: _____

Please read: This questionnaire is designed to give the doctor information as how your neck pain has affected your ability to manage everyday life. Please answer each section and mark only the ONE box that applies to you.

SECTION 1-PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6-CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7-WORK

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 8-DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities

Lemire Chiropractic Spine & Sport Inc

Low Back Pain and Disability Questionnaire
(Modified Roland-Morris)

Name _____ Date _____

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- I stay at home most of the time because of my back
- I walk more slowly than usual because of my back
- Because of my back, I am not doing any jobs that I usually do around the house
- I avoid heavy jobs around the house because of my back
- Because of my back, I use a handrail to get upstairs
- Because of my back, I go upstairs more slowly than usual
- Because of my back, I lie down to rest more often
- Because of my back, I have to hold onto something to get out of an easy chair
- Because of my back, I try to get other people to do things for me
- I stand up only for short periods of time because of my back
- Because of my back, I try not to bend or kneel down
- My back or leg is painful almost all of the time
- I find it difficult to turn over in bed because of my back
- I get dressed more slowly than usual because of my back
- I have trouble putting on my socks (or stockings) because of my back
- I sleep less well because of my back
- Because of my back pain, I am more irritable and bad tempered with people than usual

Score _____

Thank you for your cooperation.